HB 10-1332 Colorado Medical Clean Claims Transparency and Uniformity Act Task Force

Two-day meeting: Tuesday, May 21, 2013 (11:00 a.m. – 3:30 p.m. MDT) and Wednesday, May 22, 2013 (7:30 a.m. – 2:00 p.m. MDT)

Location: University Physicians, Inc., 13199 East Montview Blvd., Aurora
The Lilly Marks Boardroom, 1st floor
Parking lot off Victor Street

Call-in number: 1-800-866-740-1260, ID 8586314#
Web Login:
https://cc.readytalk.com/r/qnka3qv6u6mb

Facilitator: Barbara Yondorf, Yondorf & Associates

Agenda

Day 1—Tuesday, May 21, 2013

11:00 AM **Welcome & Introductions**

11:00—11:15 AM **Housekeeping**
- Approve April 2013 meeting minutes (Attachments A)
- Review of agenda
- Meeting procedures
- Thanks to University of Colorado Health for sponsoring the catering for 5/21 and 5/22.
- Legislative update – SB 13-166 (Attachment B)

Committee Reports

Committee Reports: introduce committee members; committee principles (if applicable); committee scope of work; report of activities to date; recommendations (draft and proposed consensus); issues to be resolved or investigated; questions for the full task force; next steps.

11:15—11:30 AM Edit Committee—Beth Wright and Mark Painter
- Information items (Attachments C-F)

11:30—11:40 AM Specialty Society—Tammy Banks/Helen Campbell

11:40—12:15 PM Payment Rules Committee—Lisa Lipinski
- **CONSENSUS ITEM** Co-Surgery (Attachment G)
- **CONSENSUS ITEM** Team Surgery (Attachment H)

12:15—12:25 PM Working lunch to run concurrently with Payment Rules Committee

12:25—2:00 PM	Payment Rules Committee continued – Lisa Lipinski • **CONSENUS ITEM** Bilateral Surgery (Attachment I) *Note: The Co-Surgery, Team Surgery and Bilateral surgery rules were distributed previously (5/12/13).* • **CONSENSUS ITEM** Revisit Assistant at Surgery – Co-chairs (Attachment J)
2:00—3:15 PM	Data Sustaining Repository – Mark Rieger/Val Clark • Data analysis of Assistant at Surgery
3:15—3:30 PM	Public Comment
3:30 PM	Adjourn for the Day

HB 10-1332 Colorado Medical Clean Claims Transparency and Uniformity Act Task Force

Wednesday, May 22, 2013 (7:30 a.m. – 2:00 p.m. MDT)

Call-in number: 1-800-866-740-1260, ID 8586314#
Web Login:
https://cc.readytalk.com/r/omok8hfkwwg6

Facilitator: Barbara Yondorf, Yondorf & Associates

Agenda

Day 2— Wednesday, May 22, 2013

7:30—8:00 AM	Continental Breakfast
8:00—8:20 AM	Program Management and Finance – Barry Keene
8:20—10:00 AM	Applying the Process continuing discussion of 5/21/13 • How does the task force use data/public comment?
10:00—10:15 AM	Break
10:15—11:45 AM	Applying the Process (cont'd) • Summarize - Facilitator • Public comment process • Website
11:45—12:15 PM	Lunch
12:15—1:30 PM	Review Task Force Work Plan for 2013-2014 Committee chairs discussion (to be sent under separate email) • Recipe Tracking Sheet – update (Attachment K)

- Monthly Co-chair meeting

1:30—1:50 PM Other Business
- RFP status update
- How to staff management for project

1:50 – 2:00 PM Public Comment

2:00 PM ADJOURNMENT

Attachment A

DRAFT

HB10_1332 MEDICAL CLEAN CLAIMS TRANSPARENCY AND UNIFORMITY ACT TASK FORCE
Executive Summary of Meeting Minutes
April 24, 2013, noon-2 PM, MST
Call-in Number: 1-866-740-1260
Conference ID: ID 8586314

Attendees:
- Tammy Banks
- Jim Borgstede, MD
- Helen Campbell
- Dee Cole
- Tom Darr, MD
- Kim Davis
- Mariane Finke
- Wendi Healy
- Amy Hodges
- Barry Keene
- Lisa Lipinski
- Kathy McCreary
- Marie Mindeman
- Doug Moeller, MD
- Ray Painter (Standing in for Mark Painter)
- Mark Rieger
- Nancy Steinke
- Fred Tolin
- Beth Wright

Staff :
- Connor Holzkamp
- Barbara Yondorf

Public:
- Diane Hayek (ACR)
- Jenny Jackson (ACS)
- Pam Kassing (ACR)
- David Mackenzie (ASAP)
- Stephanie Stinchcomb (AUA)

Meeting Objective (s):

Key:
-TF = Task Force
-TFM = Task Force Member
-CC = Co-Chair

Parking Lot:

April 24, 2013

DISCUSSION

ROLL CALL & WELCOME:

By the last roll call there were 19 Task Force Members in attendance.

Barry noted a couple corrections to the minutes:

- Deb "*Mcfedan's*" name should just be "*Fedon*"
- Diane Hayek was listed as a TFM and needs to be moved into "public" section

ACTION ITEM: Minutes Approved With Above Changes

It was noted that the TF has a two-day, face-to-face meeting next month, at the University Physician's Building in Denver, in Mark Lilly's Boardroom.

- May 21, 2013; 11:00 a.m. to 3:00 p.m. MDT
- May 22, 2013; 7:30 a.m. to 2:00 p.m. MDT

EDIT COMMITTEE—BETH WRIGHT AND MARK PAINTER

The Edit Committee has been working hard with Mark Rieger to work out the specifications on the assistant surgeon rule.

Beth W: We were talking about Assistant Surgeon in terms of what we would publish for providers. Would we be just publishing the ones that are not eligible for reimbursement? The Committee's recommendation was to publish a list similar to the CMS file, where you would have every code, an Assistant Surgeon Column, and a simple 'yes' or 'no'.

Tammy: When talking about this rule we keep saying 'payment' or 'reimbursement' and I am uncomfortable with that terminology because I don't think we are telling anybody that they have to pay or not pay. What we could say is '*something is eligible for reimbursement*' or '*not subject to AAS restriction.*' For Bilateral we use '*subject to/not subject to the reduction*.'

Marilyn: Ok. Does anyone have any concern with this?

There was no one opposed to the proposed language.

Marilyn: Ok then. We will have to remember to not use shorthand in our discussion and say '*eligible'* or *'not eligible.'*

Beth W: I will try my best to use different language.

Tammy: Ok. I am not trying to be difficult here—the rule can only say when something is subject/not subject to it because it may not be covered with the provider, they could have a different type of policy, there could be audit situations, there could be limited medical policies, etc. We don't know the contract relationships between the payer/provider or benefit plan for individual patient and we need to be careful.

ACTION ITEM: Proposed language accepted regarding the term 'reimbursement'. TF will use '*eligible/not eligible',* and *'subject to/not subject to AAS restrictions'*.

Beth W: Right, point taken. So that's where we stand today with the Edit Committee. I think we are in a pretty good pace with Assistant Surgery, and have created what we are calling the '*Rule Recipe Template*', which we will be calling for consensus on later today. Consensus on this item will help us with the next step, which is to finish the other 4 rules we have been working on (age, co, team, gender). At this point, we are a little contingent on the work of Lisa and the Rules Committee regarding age, gender, co, and team. Our plan is to present those at

the next Edit Committee meeting which will be on May 15 in order to have them ready for consensus by TF meeting in May.

Barry: Anything that is up for consensus needs to be submitted five business days in advance. We are meeting on the 21st and 22nd so that is going to be difficult here.

Beth W: Well if we got it out on the morning of May 16, then it could go for consensus on the second day of the meeting. Another option is that I could draft the documents and send them to the committee for comment.

Marilyn: I think if you and Mark draft the recipe's and circulate to the rest of the committee with a deadline that would suffice.

Beth W: Ok. So Mark and I are meeting on the 8th, and if we wrapped it up on the 8th or the 9th I could send it out, get some consensus, and then send it out to you and Connor in order to have that five days.

Barry: That sounds good, and we really appreciate that kind of effort. It is probably going to take efforts like this to hit our deadlines.

Beth W: Ok. However, in order for us to do this we will need the documents from the Rules Committee before the 8th.

Lisa: We are meeting tomorrow and I will have a better gauge as to where we are at, but I will really make an effort to get it done.

ACTION ITEM: Beth Wright will work with Mark Rieger to create rule recipe for other four rules (age, team, co, and gender) in order for the documents to be submitted for consensus at the May 21-22 meeting; Contingent on the work of the Rules Committee.

RULES COMMITTEE—LISA LIPINSKI

The following conversation is referring to *Attachment 1* in the agenda, *Bilateral Procedures Payment Rule.*

So we have added some things since we sent it out to you. We changed the disclosure statement to "context" and rewrote that first part. The other thing is that this was sent out to the federation to look at and one of the things we got back is that it is a little confusing (what should/shouldn't be billed etc.). There's some highlighted stuff as well, where we wanted the TF to examine the language of the term *appropriate modifier.* So we are having a committee meeting tomorrow and any comments that anyone can provide before that will be greatly appreciated, but we will accept any comments submitted to us before May 1.

ACTION ITEM: Lisa will distribute document after Rules Committee meeting tomorrow, and will accept comments on it before hard deadline of May 1, 2013.

At this point, Barry asked for those who arrived late to identify themselves. The following people had joined the call:

- Regina
- Dee Cole
- Wendi Healy
- Mariane Finke
- Marie Mindeman

SPECIALTY SOCIETY—TAMMY BANKS AND HELEN CAMPBELL

Tammy: No updates at this time. We have continued to reach out to the specialty societies on the various issues as the rules are drafted; Lisa also has set up a process that we're able to vet rules prior to the Rules workgroup.

Barry: Thank you. We are finally starting to see the specialty societies show up in the way that we have hoped—so I just wanted to thank the specialty societies, as well as the Specialty Society Committee for their continued support.

DATA SUSTAINING REPOSITORY COMMITTEE—MARK RIEGER

Back at the February TF meeting, Mark R led the TF through a data analytics prototype that used the "recipe" from the Edit Committee to create the final list. The Edit Committee took the information from that prototype and re-worked the logic with the intention of running the prototype again. Mark re-ran the analytics last week and created a spreadsheet that compared the previous results with new data. This document (Attachment B) was displayed, and was the centerpiece of the Discussion that was led by Mark Rieger.

Mark R: Basically, you see two tables on this document; the top table shows the most recent logic. Essentially we ended up at almost the same place as before, but the logic is cleaner this time. Highlighted in Yellow are the similarities between the two types of logic. As you can see, the *always* bucket stayed the same.

Barb: Does anyone have any questions for Mark?

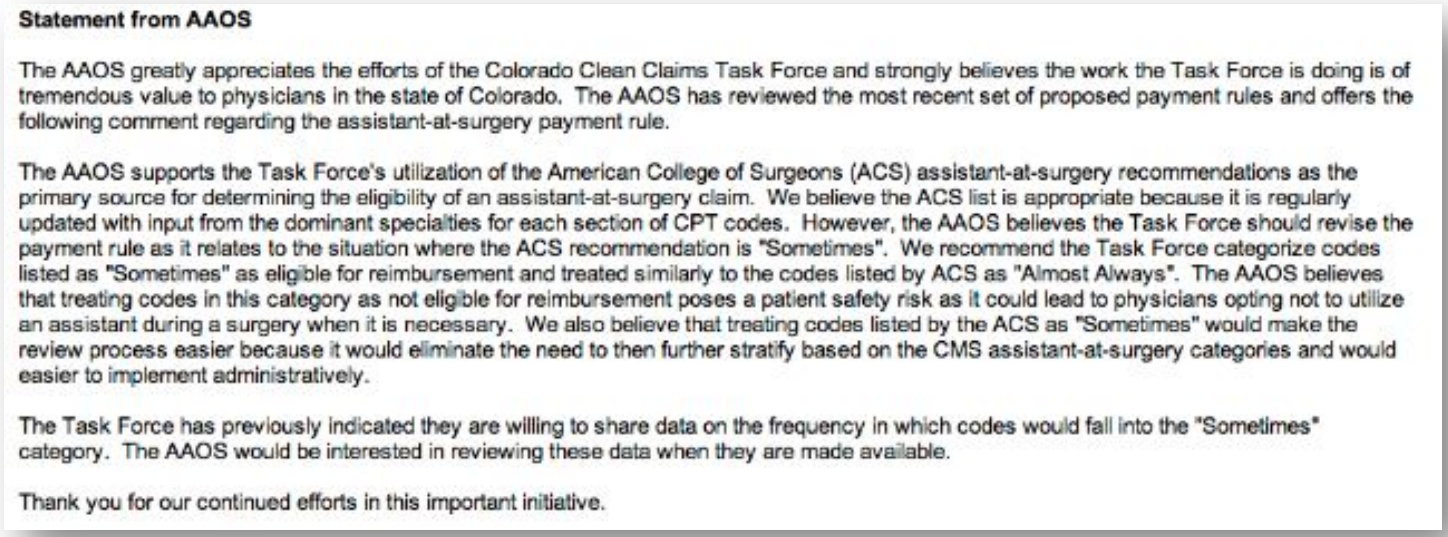
Barb: Ok so the idea is that this feeds into the Assistant Surgeon Rule Recipe (Attachment C). So we will put that up on the screen.

Barry: Before we leave this I want to draw attention to the 378 *sometimes/sometimes* codes that are assigned to *never*. Let's remember that number because I know it will be brought up later.

Barb: Ok. So my understanding was that we were trying to get consensus on Attachment A (*Assistant Surgery Rules Recipe* was displayed). At first glance the data does look very similar, but there are some definite differences. I believe we have an email that we received from the ACS as well as from the AAOS—give Marilyn and I a couple minutes and we will pull it up.

Barry: While they are pulling that up I will talk about this for a minute. So as a Task Force we agreed that we would assign codes in the *sometimes/sometimes* category to *never,* but we have received a couple thoughtful responses; one from the ACS and one from the American Academy of Orthopedic Surgeons (AAOS) that recommended we change the never to an *always.* If there are members that are present that felt strongly about the *never*, we want to hear your thoughts. Likewise, we would welcome, and appreciate any thoughts from anyone present from the ACS or AAOS.

Marilyn displayed the letter that was sent to the TF from the AAOS. This email was not included as an Attachment to the agenda, and is shown below:



Statement from AAOS

The AAOS greatly appreciates the efforts of the Colorado Clean Claims Task Force and strongly believes the work the Task Force is doing is of tremendous value to physicians in the state of Colorado. The AAOS has reviewed the most recent set of proposed payment rules and offers the following comment regarding the assistant-at-surgery payment rule.

The AAOS supports the Task Force's utilization of the American College of Surgeons (ACS) assistant-at-surgery recommendations as the primary source for determining the eligibility of an assistant-at-surgery claim. We believe the ACS list is appropriate because it is regularly updated with input from the dominant specialties for each section of CPT codes. However, the AAOS believes the Task Force should revise the payment rule as it relates to the situation where the ACS recommendation is "Sometimes". We recommend the Task Force categorize codes listed as "Sometimes" as eligible for reimbursement and treated similarly to the codes listed by ACS as "Almost Always". The AAOS believes that treating codes in this category as not eligible for reimbursement poses a patient safety risk as it could lead to physicians opting not to utilize an assistant during a surgery when it is necessary. We also believe that treating codes listed by the ACS as "Sometimes" would make the review process easier because it would eliminate the need to then further stratify based on the CMS assistant-at-surgery categories and would easier to implement administratively.

The Task Force has previously indicated they are willing to share data on the frequency in which codes would fall into the "Sometimes" category. The AAOS would be interested in reviewing these data when they are made available.

Thank you for our continued efforts in this important initiative.

Tammy: So they are questioning the same question we raised before; why sometimes would be assigned to a "never?" I think there is a bigger issue here, whoever is the owner of a code set, they need to be involved. Regardless of what the outcome is, it is just common courtesy, and I hope this can be a lesson for this group—that we reach out to those before we delve into different rule sets.

Beth W: And Tammy we did reach out to them a long time ago; Mark Painter had conversations with ACS before we even began Assistant Surgeon, and this same level of engagement was not available at that time. So I am very pleased that we are starting to see some more involvement from these societies, but they were engaged a long time ago.

Tammy: This is the beginning of a very cool initiative, and this is why I am raising this point. It is important that we reach the right people within these societies.

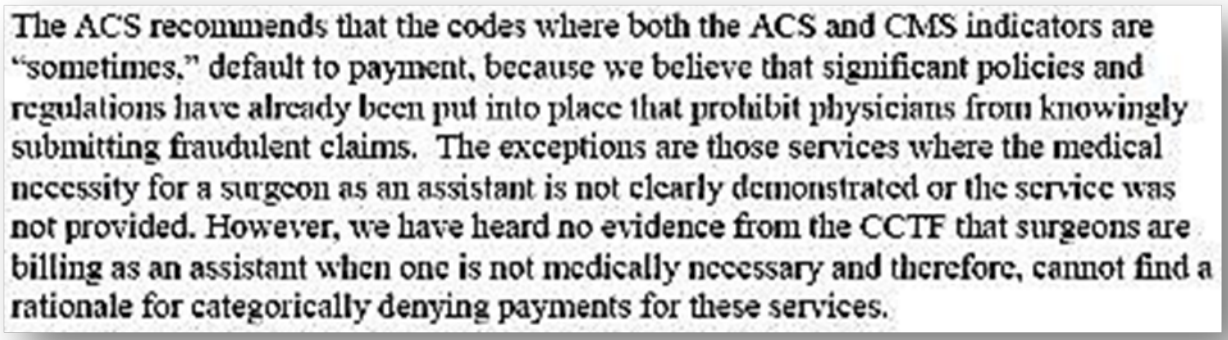
Barb: Ok. So we have the email from AAOS on the screen. Would you like to speak on this Beth?

Beth W: I would be happy to since the Committee vetted this document. So if I am understanding the AAOS correctly, they are saying that we should use the ACS list, not the CMS list, and wherever there is a *sometimes* recommendation from ACS you would make it *always*. So this poses a couple problems. It doesn't offer a solution for when ACS does not publish a position on a new code. I think they update about every five years—so we needed a plan in place for how to handle these when ACS does not give an opinion. And that is a big part of what Mark was trying to do, which is try and see if ACS would be willing to publish annually. We have agreed that the clinical approach is better than using CMS, but we need a solution for when ACS does not have a recommendation. Another thing I am struggling with, and I would love to hear from someone on the phone about, is if they think it should be *always* then why don't they make it an *always?* From a payer perspective it feels like at a specialty society level they may not have been able to get consensus within the organization on whether it should be or shouldn't be, or that there should be more criteria around where a *sometimes* would be considered. So the administrative expense piece is why we were looking at creating a list that gave a way to gap-fill when ACS doesn't give a response, and for the *sometimes* when it could go both ways were using CMS. So if the Edit Committee wanted to reconsider the position and not use CMS, we would have to have a source when there is no code determination from ACS.

Barry: Thank you Beth. I do not see any way other than resort to CMS when codes are not addressed by specialty society. I wish the specialty societies would address 100% of them because I would much rather take that, but

Beth makes a clear point here—we have to have some way of dealing with this, and if the specialties have not addressed them what do they suggest we do? So let's look at the email from ACS—Marilyn, can you read the paragraph that contains the ACS final recommendation?

Marilyn displayed the email from ACS for the group to see, and read the following paragraph:


The ACS recommends that the codes where both the ACS and CMS indicators are "sometimes," default to payment, because we believe that significant policies and regulations have already been put into place that prohibit physicians from knowingly submitting fraudulent claims. The exceptions are those services where the medical necessity for a surgeon as an assistant is not clearly demonstrated or the service was not provided. However, we have heard no evidence from the CCTF that surgeons are billing as an assistant when one is not medically necessary and therefore, cannot find a rationale for categorically denying payments for these services.

Mark R: One of the things I do not hear us addressing is the fact that we have consistently said throughout this process that any surgical event could have medical justification for Assistant at Surgery, even though it is in the *never* category. I think that this is getting at what ACS is saying—we agree that if the medical circumstances justify an Assistant Surgeon, regardless of what the procedure code is, the payer and provider have the right to do something different than what is in the published rule. This exists for basically any rule that we are going to promulgate. The other thing, which is seemingly obvious to me, is if the ACS believes that the *sometimes* category should be *always*, then why don't they change it to *always*? I do not understand how you can make an administrative simplification argument that *sometimes* is a better way to describe a rule. To me, *sometimes* will always create ambiguity, and therefor will always be more expensive. So if the goal is to remove the administrative burden, then remove the ambiguity. The ACS has the right to change their position on any procedure code, and 100% of the codes that are going to be in the *never* category, it is possible that the clinical circumstances could justify a different outcome.

Beth W: That is a reason why people agree/disagree with the CMS approach. When they were doing the 80-20 rule I think CMS said, "I need an approach. If I am looking at all of the codes that end up in the *sometimes* bucket and 80% of them I am always denying, that is the approach they took for administrative simplification reasons. I have a problem with the last part of that email in that I do not believe that we have ever implied that the logic was due to any fraudulent submission of claims. The policy decision about taking the *sometimes/sometimes* and making it a *never* was more in line with CMS in that we said, "listen, we looked at them and feel that the volume is so low, and if we get down to this and nobody can make a decision we are just going to say *never."*

Barry: This is my recollection as well Beth—it was nothing more than a simplification strategy. So our task here has two levels: The other AAOS email regarding the elimination of the CMS list, and this topic regarding the ACS's concern with the *sometimes/sometimes* category. I would like to address the ACS recommendation first because I believe we took a specific approach to this, and now we are being asked by the society whom we source for this group of codes to take a different approach to it, and I think we have to take this request seriously and figure out where we are going with this. It either has to be a *never* or an *always* and we need to debate this at the TF level to make this decision. As far as the patient implications, I see a potentially compelling argument being made around patient care. Frankly, we are talking about 378 codes, and I think it would be interesting to see what these codes actually are, but we need to make an informed decision here.

Ray: I think that this letter from the ACS made some very good points. One being that there rationale is clinical in nature as opposed to payment in nature. Clinically, I can share with you that there are times where you need an assistant, where other times for the same procedure you do not. On the other side of the coin, I do not see that anyone would charge for an assistant unless they absolutely had to have one. Assistant at Surgery does not pay the assistant very well. With the shortage of physicians I would be surprised if any of the payers are reporting any major abuses, but would love to hear if they are. I think that the ACS suggestion to make the *always* into a *never* is a good one because the *never* will trigger a denial which causes administrative redundancies and costs money.

Barry: Thank you Ray, we appreciate you being on the call today. Mark Rieger, do we have any frequency data for these 378 codes we are talking about?

Mark R: No we do not.

Beth W: And Barry you should know that the volume we are talking about is actually a little bit more than 378. So the number 378 is when ACS made it a *sometimes* and CMS made it a *sometimes*—there is a higher volume of codes where ACS has not given a position. So the volume is actually a little higher than 378, and I think they are actually in the N/A bucket.

Mark R: It seems to me that it is very important to draw a circle around the right set of codes. If you add up all the ACS *sometimes*, there was roughly 1600 of them—we moved 685 of that group into the *always* per the CMS recommendation. From there we had roughly 900 codes left, 553 of them were moved to *never* per CMS recommendation. Then you have the remaining balance of 378. To me it doesn't make sense to take a subgroup of the ACS *sometimes* and deal with it differently than the other groups. In other words, there is a consistency to the logic that the Edit Committee applied to all of the *sometimes* codes. I do not understand the difference between the 378 *sometimes* we are talking about, and the rest of the *sometimes.*

Doug: I think it has to do with the *sometimes* determination and the frequency that it actually occurs in the way that CMS looks it. If a *sometimes* occurs on a claim more than 5% of the time, they flip that switch on *sometimes* to *allow/always.* From Mckesson's perspective, when we first started developing this rule years ago, the issue was not with the ACS criteria, but an understanding that sometimes means it is sometimes possible to do a surgery without an assistant—in a an unspecified faction of patients an assistant surgeon is appropriate. Assistant surgeon in the ACS study is literally another physician, but in claims processing sometimes is it a physician assistant, sometimes it is an advanced practice nurse, and sometimes those additional reports are actually being done at the discretion of the physician, not out of medical necessity, but because some of those personnel are not available in the operating room (O.R.), or there is a particular piece of technology that is required etc. When McKesson created this logic, we said there should be a better mechanism for specifying in those patients for which medical necessity exists. To put that on the claim, either with a modifier that says I have critical information to attach, or something to distinguish those instances that are billed out of medical necessity from those that weren't. Our issue was never with ACS, or the integrity of their determinations, but was always a challenge in terms of working with health plans for reviewing the appropriateness of reporting the medical necessity of the assistant surgeon. I do not exactly know how to solve it, but these are just a couple thoughts as to why this problem doesn't quite go away.

Nancy: I would like to respond to the comment that the pay for surgical assistant is not worth using one when you don't need one. We don't see an issue when the physician is the surgical assistant, but we have a *huge* issue when we have non-contracted, technical surgical assistants going ten times more than the surgeon has billed, and because they are out of network we have to protect our members and sometimes pay these outrageously billed charges.

Beth W: I agree Nancy. From a WellPoint perspective similar situations happen. What we see is some doctors like to have their own staff in the O.R. and do not want to use the people in the hospital. Unfortunately that is not

always for a procedure that warrants it. So I do not think that anybody is using the MD's inappropriately but we do see this happen all the time—just not from the physician perspective.

Barb: Ok. So I am trying to decide how you all want to come to some sort of conclusion on this. Ideally we want to get to some sort of consensus today on the *Assistant at Surgery Rule Recipe*, so you can formally send it out for comment. At this point, did anybody hear anything particularly compelling that you feel very strongly that we should not, at least for now, go with the rule recipe as written, which is that *sometimes/sometimes* becomes *never?*

Tammy: I was wondering if Beth or Nancy could give me more information as to how, from a medical policy perspective, this can be addressed. Is there a modifier that can be used to identify those situations, or are those situations pulled into an audit?

Beth W: So from a WellPoint perspective we would have concerns about having two separate lists of policies based on your provider's specialty—sort of as parents of discrimination. But there is a modifier for non-MD services, but we have never had a specialty-specific policy, and our legal area has frowned upon that.

Mark R: So I just wanted to clarify the question that is on the table. Is it *sometimes* becomes *always,* but only for a non-MD assistant?

Beth W: Actually, I think it is reversed. For the MD's they want to make it *always* and for non-MD's make it a *never*.

Tammy: Actually I did not make any statement. I just wanted to brainstorm alternative ways to handle these issues. If the volume is small and we can handle it other ways or by using a modifier, it would make more sense than adding administrative cost to the physicians when they are reporting these codes.

Mark R: I agree with that Tammy, and I think that the centerpiece of this conversation, for this rule as well as other rules, is that we are going to have to have a more elegant way to deal with the medical circumstances. Just so to make sure I understand, is it fair to say that the purpose of the *sometimes* designation was to find the line between clinical circumstances and the fraud protection? In other words, to say *always* is an overstatement for reasons that we've heard—some percentage of the time (less than 100%) they might use an assistant surgeon. So the way I see it, there is a need for a *sometimes* category if you take a purely clinical view on this. If I am wrong on this I would like the ACS folks to weigh in.

Jenny: So our Assistant at Surgery is specific to surgeons. There is a piece in our introduction that tells you that this does not address the use of non-physician providers. So our report is strictly about the use of another surgeon, I can't speak on the non-physician providers. The other piece you are correct on, if you put something in the *always* category there will be an expectation that it is always billed that way. The codes that are in our *sometimes* category can be done safely without an assistant surgeon—we can expect the patient will still have a good outcome, and we can expect that it may not always be done with a surgeon.

Beth W: I would like to understand the non-MD position. So do you make this not apply to them because you do not want to represent them? Or do you actually believe there is a difference in the assistance provided between an MD and a non-MD? At WellPoint we have always applied the list of pay or not pay to everybody that provides an assistant surgeon, MD or not.

Marie: From a CPT© perspective, when you report the Assistant at Surgery it would be presumed that the reason the modifier is necessary is to allow payers to recognize that the same service is recorded by two individuals, on the same date, for the same patient. It is also to make the assumption that both of those individuals are qualified to report a CPT© code. The addition of the modifier helps to override the assumption that the patient wouldn't be having that procedure done by two individuals on the same day.

Jenny: So because all of the specialties that review these codes are surgical specialties, we do not represent the non-physician providers. It is also my understanding that some of these organizations have their own Assistant at Surgery report. So we speak specifically to MD surgeons because they are the membership we represent.

Beth W: So I understand that, but what I don't understand is they are the ones bringing in the non-MDs. I understand that it is mostly for financial reasons. I guess I wonder how many of your specialties are really only talking . . .

Mark P: I think I have the same question. I think it is very important to have ACS clarify that nuance. In other words, would they say there are *sometimes* or *never* codes that they would say are eligible to be *always* with a non-MD? In other words, one way you could take what they're suggesting is the specialties are irrelevant. While they only represent physicians, as a practical matter the specialties are irrelevant. If that individual is approved to do the procedure in the facility in which they are operating, then the credentials are irrelevant. It is really about whether another physical person is required to create a safe clinical environment. The mechanics for a provider to submit justification for the *sometimes* category already exist, we do not need to create that. So what is the simplest way for a provider to submit this justification? If the procedure is a 10, 20% occurrence you don't want to make it an *always.*

Barb: O.K. So at this point we would love to hear from those of you who haven't spoken yet.

Wendi: From the perspective of having coded a lot of these procedures, there are many times where an assistant is used in order to make it easier/faster for a physician to perform a surgery, which is absolutely understandable. I agree with the discussion that *sometimes* cannot be changed into an *always.* You know, at least with CMS when it says *never* it truly means never, but we have made sure to include language that these are appealable. So I would agree with the rule as it stands, but I think it was a good discussion to have, and it helps us understand where ACS is coming from. I think their point is still valid but I still stand by the rule as we wrote it.

Kim: Our experience is that our payers generally have the same assistant surgeon rule for non-MD's and MD's. In other words, if the procedure is eligible there is no differentiation as to whether they will allow a P.A. to do it or if they require an MD. So I think we need to stay within the scope that we had previously defined—just assistant surgeon regardless of provider type. I tend to agree with Wendi; However, I do think we need to carefully consider the implications of publishing a recommendation that ACS does not support.

Barry: I would like to hear from some payers what the implications are of changing the *sometimes/sometimes* category to *always.* It is my understanding that a physician is not going to bill for an assistant that they are not using—that would be fraud I presume. Wouldn't it just open it up to make it simple? When they have the assistant they do not have to write an appeal or anything, they just bill it that way, or am I being too naïve?

Helen: I think that one of the things that Kim actually brought up is the fact that sometimes in a larger hospital scenario you might have some assistant surgeons that are available to make the process move more quickly rather than out of medical necessity. So they would use the assistant surgeon but it would not necessarily be billable under these guidelines.

Barry: Helen, I think you may have joined late. What we are going over right now is a letter that we received from ACS. They wanted us to change the *sometimes/sometimes* category from a *never* to an *always.*

Tammy: I would really hate for this group to ask ACS to move *sometimes* to *always.* The last thing we want to do is require physicians to have an assistant at surgeon in instances where they are comfortable doing without. Everything that has been raised as a reason to not move the *sometimes* to an *always* in our system, are these isolated instances that can be pulled out and handled in a different way? It seems like people know where the settings are, where things are happening, and as we do more of this pre-audit before claims are paid, is that where

this stuff can be handled, versus penalizing people for making the best decision based on the patient. If under my benefit plan my surgeon can have an assistant surgeon, I sure want him to have that option.

Beth W: I will tell you from the appeals that we have looked at for assistant surgeon, and more often than not we are upholding them. We do see a lot of the situation that Helen was describing earlier where the physicians are bringing in assistants that act as a surgical tech. Also when we pay the hospital an O.R. charge, they have an obligation to pay all the staff that is in there—so all those non-MD assistants are covered in that fee that we pay. Sometimes the situation occurs where the provider prefers to have his/her own P.A. who knows there every move be by their side, even when they do not necessarily need someone in there.

Tammy: Can there be a modifier indicating when it is a non-physician?

Beth W: There is a modifier—HCPC modifier AS.

Tammy: O.K. So could one of the rules be when it is an MD assistant it would be accepted, and when it is AS you would ask for additional documentation with a claim.

Beth W: Well since the trend is more to use non-physicians than physicians, that would generate a lot more manual reviews.

Tammy: Well actually it wouldn't because you would be doing the ones you are asking for a manual review right now. You are asking for everybody to do it, I am trying to figure out how do we reduce. . .

Beth: I am not asking to do any manual reviews. In this position we are publishing a list and telling providers here is where you are going to get paid and here is where you will not. If you have a clinical situation that you truly feel warranted an assistant at surgery—maybe in one case you don't typically need an assistant but the patient was obese and it required an assistant. In cases like this you would be able to appeal.

Tammy: But those are the *never;* that wouldn't be for the *sometimes.* So how do we focus on that category? I like Mark's idea of looking at this at a higher level; how do we get to the point where the payers are not paying too much, and the providers do not have much burden? The only issues that I have been hearing is non-MD's, and so if they are non-MD's, if we can identify when that is, how do we put safe-guards—and is this the appropriate place to put those safeguards?

Beth W: That gets back to my earlier comments that from the legal perspective we would have issues with having two separate processes based on a providers specialty. It could be perceived to be targeting and discriminatory—I could see the P.A. society and the practitioners' society saying, "we offer the same services as an MD, why are you treating us different?"

Tammy: Well I guess the question is why are you not accepting them as assistants then?

Mark R: I just want to say, I am not hearing that we are turning this into a specialty conversation. I think it is very important that the orientation of the rule, as it has been from the beginning, remain insensitive to specialty, and it needs to stay there until we have sorted out the rule. I do not think anyone is suggesting that the 378 we are debating here are all being done by non-MDs. The ACS's orientation to this policy development is clinical. For better or worse, our orientation cannot be purely clinical because nobody around the table wants to have every claim pend for review. So it is really important that we find that compromise, where we all accept the fact that in the interest of the 90-95% of claims we want auto-adjudicated, we are going to accept some imperfection in the rule. 100% of the *never* codes are eligible for reimbursement.

Kim: Is it an option, and do we want to get into the business of creating a handful of qualifying circumstance modifiers that serve as a compromise to this rule?

Wendi: I do not think we can make code. I think we have to use what CPT© has given us, or anything else that is already industry standard.

Barb: So it sounds like people have a grasp as to what the problem is, but don't have a good legal, consistent, effective, proper modifier, coding solution that's elegant for this. So in the shorter run I think some sort of decision needs to be made so you can move the process along. I think that this conversation could just go on and on, and like Mark Rieger said this is not unique with this one particular rule. So with that is there someone who cannot live with this rule process as it is written, or perhaps with some specific language issue?

Mark R: I just want to clarify that we only need to get this recipe to the point that we feel comfortable releasing it for public comment.

Barb: Right. So is there anyone out there that would be strongly against sending this rule recipe out for public comment?

Tammy: We would be strongly against moving forward without getting more information and working with ACS to work out some of the issues that were raised today before bringing this to the public.

Barb: O.k. So is there any way that this process could happen simultaneously?

Tammy: I am very concerned with putting this out without them thoroughly understanding that we vetted this out and have some sort of solution to this.

Jenny: We are definitely in agreement with the AMA. We have 21 other specialties signed on to our report. Without discussing this with them we do not agree with moving this forward.

Tammy: And we would welcome, if Jenny agreed, meeting with these specialties at our next RUC meeting to review and discuss this rule.

Jenny: On top of the 21 specialties we have to be mindful that some of those are umbrella organizations for smaller sub-specialties.

Barry: Tammy when is the next RUC meeting.

Marie: Tomorrow

Barry: O.K. Well excuse me if I am confused, but it seems to me that we have been after the specialty societies about this discussion for a very long time. I am confused with your claim that decisions have been made in the absence of consulting with the specialty societies.

Tammy: Calls have been made but there was no formal meeting between the ACS and the specialties to take a look at this.

Barry: What do we need to do to ask them to do that?

Bob: Part of what we would need to do is to get the data that we requested which is the frequency. We need to find out the denial rates because we don't see the problems that exist that provides a rational for the denied codes in the *sometimes/sometimes* bucket.

Barb: I am sorry to interrupt, but we have about five minutes left. So this conversation has gone on a long time and the question is how do you get it out for public comment? You had a rationale section—it is possible that you could take the richness from today's conversation and add it to the rationale section. In the meantime see if it is

possible to get frequency data and continue the conversation. You are going to revisit this conversation no matter what because it is called for in the process timeline once you get all the comments in.

Barry: Where is the source of this frequency data? Does that have to come from a payer?

Mark R: I would be happy to provide some frequency data. We are probably going to have to have a couple of conversations about it because I don't know for instance what percent of Colorado providers I have data on.

Doug: It sounds to me that for the *sometimes/sometimes* codes, and I would go back to the original ACS list and look at the whole group, we would want to know in the data sample that is surveyed, how many claims are in that data sample for the denominator; and what the frequency is for all those codes, and then what the percentage of those is that has each of the four assistant surgeon modifiers so that we could have some clarity on how often those things are actually occurring. The codes that I know of where assistant surgeon is problematic are in the knee arthroscopy codes, and to a much letter extent, a couple of ophthalmology codes where an assistant at surgery is challenged. I think if we are going to do that survey, and I could participate in getting a data sample, I do not have a turnaround time for that but I could provide this.

Beth: I have a comment to make; I understand the urgency of getting this out for public comment to test the process more than for the actual rule, could we switch the *sometimes/sometimes* to always for that public rule comment?

Jenny: Yes we would definitely agree with that.

Doug: Excuse me, so are you suggesting that we change the rule logic from *always* to *never* right now? Then what do we do, change it back after the comment period? Or are we going to change everything we have come up with to this point?

Beth: So if I understand the position of the ACS it is when you have the two *sometimes* categories, you would like that to be an *always* instead of a *never.* We haven't even talked much about the AAOS letter, so we will have to address this.

Barry: Yes, and after reading both the AAOS statement and the ACS letter it appeared to me that there were distinct differences between the two. My understanding is that the AAOS wants us to get rid of the CMS implications altogether and the ACS *sometimes* category should be an *always.* The ACS appeared to accept the CMS implications, but wanted the *sometimes/sometimes* category to be changed from a *never* to an *always.*

Bob: You are correct in that we were speaking to the *sometimes/sometimes* category, and we certainly do not agree that it should be assigned to *never.*

Barb: I know some people are going to have to leave the call at 2:00, and I have been reading through your bylaws. In cases where there is a logjam, a vote can be administered to reach agreement. So I see two options: A. Accept the rule largely as it is written, but do some serious massaging to address some of the concerns that have been raised; while simultaneously doing more research, having more discussion, and decide what to do with the frequency data. Alternative B is to change the *sometimes/sometimes* to an *always.* Once again do more research, have more discussion etc. So those are the two alternatives, is there a third alternative that I missed? O.K. so let's try this; out of all of those people who are TFM, how many of you support Alternative A?

Barry: I am going to recommend that we invert this and ask for those who oppose alternative A because I think it is going to be a smaller number.

Barb: Sounds good to me. So all those who are opposed to alternative A please state your name.

The following people came forward and voted in opposition of alternative A:

- Tammy (AMA)
- Ray Painter

Barb: O.K. So I will take this to mean that the group has agreed to go forth with alternative A.

Tom: I want to say something: Always remember that appeals are possible. We are trying to get a baseline rule set. We are also developing the process for how we are going to reconcile differences. So for those of you have concerns this doesn't mean that everything is done here. I would be willing to bet that we will continue to try to answer these questions. I would also like to say that the process that we put together is more lenient than CMS's, and they pay 95% of the time. So realize that theoretical arguments can go on for a long time but we need to get after that data to see the practical application of this, and understand that it will always be a process in place to work out differences.

Tammy: I appreciate it Tom, and this is why I opposed this today. I am concerned about the implications of how people will view this.

Marilyn: I want to add that we will continue to research this to come to a solution. I think one of the things besides getting the data, just putting these in terms of the procedure codes that fall into each of these categories would be helpful in trying to nail down what it is we are talking about.

Barb: O.K. I want to congratulate the group on what an incredibly rich conversation that was, and the trust that you have built in one another to be able to move forward temporarily is a tribute to the work of this group. Barry did you have any final comments?

Barry: No, we are way over time. This was a good discussion though and I will work with Doug and Mark to get the frequency data that will allow us to answer some of these questions. However today I believe we should call for adjournment.

The meeting was adjourned at approximately 2:07 p.m. MDT

NOTE: This bill has been prepared for the signatures of the appropriate legislative officers and the Governor. To determine whether the Governor has signed the bill or taken other action on it, please consult the legislative status sheet, the legislative history, or the Session Laws.

Attachment B

SENATE BILL 13-166

BY SENATOR(S) Aguilar, Kefalas;
also REPRESENTATIVE(S) Schafer, Fields, Ginal, Hullinghorst, Labuda, Pettersen, Primavera, Ryden, Young.

CONCERNING THE DEVELOPMENT OF STANDARDIZED RULES FOR USE IN PROCESSING MEDICAL CLAIMS, AND, IN CONNECTION THEREWITH, EXTENDING THE DEADLINES FOR DEVELOPMENT AND IMPLEMENTATION OF THE STANDARDIZED RULES, AUTHORIZING AN APPROPRIATION OF STATE MONEYS TO HELP FUND THE DEVELOPMENT OF THE RULES, AND MAKING AN APPROPRIATION.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. In Colorado Revised Statutes, 25-37-106, **amend** (2) (d) (III) (B), (2) (d) (V), and (6) (a); and **repeal** (7) as follows:

25-37-106. Clean claims - development of standardized payment rules and code edits - task force to develop - legislative recommendations - short title - applicability. (2) (d) (III) If, at the time the task force submits its report, the national initiative work group has not reached consensus on a complete or partial set of standardized payment rules and claim edits:

_____
Capital letters indicate new material added to existing statutes; dashes through words indicate deletions from existing statutes and such material not part of act.

(B) The task force shall continue working to develop a complete set of uniform, standardized payment rules and claim edits and, by December 31, ~~2013~~ 2014, shall submit a report and may recommend implementation of a set of uniform, standardized payment rules and claim edits to be used by payers and health care providers.

(V) PAYERS SHALL IMPLEMENT the standardized payment rules and claim edits developed pursuant to subparagraph (III) of this paragraph (d) ~~shall be implemented by payers~~ as follows:

(A) FOR payers that are commercial health plans, ~~shall implement the standardized set of payment rules and claim edits within their claims processing systems~~ according to a schedule outlined in the task force recommendations or by January 1, ~~2015~~ 2016, whichever occurs first; and

(B) FOR payers that are domestic, nonprofit health plans, ~~shall implement the standardized set of payment rules and claim edits within their claims processing systems~~ by January 1, ~~2016~~ 2017.

(6) (a) (I) The executive director of the department of health care policy and financing shall designate a nonprofit or private organization as the custodian of funds for the task force. The designated organization is authorized to accept and expend funds as necessary for the operation of the task force and may solicit and accept monetary and in-kind gifts, grants, and donations for use in furtherance of the task force's duties and responsibilities. Any moneys donated or awarded to the designated organization for the benefit of the task force are not subject to appropriation by the general assembly, and THE DESIGNATED ORGANIZATION SHALL RETURN any ~~such~~ moneys that are unexpended or unencumbered at the time the task force is dissolved ~~or this section repeals pursuant to subsection (7) of this section shall be returned~~ to the donors or grantors on a pro rata basis, as determined by the designated organization.

(II) THE GENERAL ASSEMBLY MAY APPROPRIATE MONEYS TO THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FOR USE BY THE TASK FORCE IN IMPLEMENTING THIS SECTION.

(7) ~~This section is repealed, effective June 30, 2012, unless the executive director of the department of health care policy and financing notifies the revisor of statutes, in writing, that the organization designated~~

~~pursuant to subsection (6) of this section has certified that, as of June 30, 2012, it has received or has available sufficient moneys to implement this section.~~

SECTION 2. Appropriation. In addition to any other appropriation, there is hereby appropriated, out of any moneys in the general fund not otherwise appropriated, to the department of health care policy and financing, for the fiscal year beginning July 1, 2013, the sum of $100,000, or so much thereof as may be necessary, for allocation to the task force established pursuant to section 25-37-106 (2), Colorado Revised Statutes, for use in developing a standardized set of payment rules and claim edits related to the implementation of this act.

SECTION 3. Safety clause. The general assembly hereby finds,

determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.

John P. Morse PRESIDENT OF THE SENATE	Mark Ferrandino SPEAKER OF THE HOUSE OF REPRESENTATIVES
Cindi L. Markwell SECRETARY OF THE SENATE	Marilyn Eddins CHIEF CLERK OF THE HOUSE OF REPRESENTATIVES

APPROVED_____

John W. Hickenlooper
GOVERNOR OF THE STATE OF COLORADO

Attachment C

HB 10-332 Colorado Medical Clean Claims Transparency & Uniformity Task Force

Edit/Payment Rule Query

Topic	**Co-Surgery**
Definition	When 2 surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) (including add-on procedure(s) are performed during the same surgical session, separate code(s) may also be reported with modifier 62 added. **Note:** If a co-surgeon acts as an assistant in the performance of additional procedure(s), other than those reported with the modifier 62, during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.
Associated CPT® [1]and HCPCS modifiers	Modifier -62 – Two Surgeons
Query logic	1) Using the CMS MPFS schedule, identify the column identified as co-surgery. 2) Any code with a '0' or '9' indicator should be listed as a No 3) Any code with a '1' or '2' indicator should be listed as a Yes
Rationale	Applying a consistent approach as recommended with Assistant Surgery logic to eliminate pended claims, the query was developed to identify codes as either allowing a Co-Surgeon (Yes) or Not allowing Co-Surgery to be reimbursed (No). We should produce a code list that has either a Y or N value.
Summary DATE	**May 10, 2013**

Attachment D

HB 10-332 Colorado Medical Clean Claims Transparency & Uniformity Task Force

Edit/Payment Rule Query

Topic	**Team Surgery**
Definition	Under some circumstances, highly complex procedures (requiring the concomitant services of several physicians or other qualified health care professionals, often of different specialties, plus other highly skilled, specially trained personnel, various types of complex equipment) are carried out under the "surgical team" concept. Such circumstances may be identified by each participating individual with the addition of modifier 66 to the basic procedure number used for reporting services
Associated CPT® [1]and HCPCS modifiers	Modifier -66 – Surgical Team
Query logic	1) Using the CMS MPFS schedule, identify the column identified as Team Surg. 2) Any code with a '0' or '9' indicator should be listed as a No 3) Any code with a '1' or '2' indicator should be listed as a Yes
Rationale	Applying a consistent approach as recommended with Assistant Surgery logic to eliminate pended claims, the query was developed to identify codes as either allowing a Team Surgeon (Yes) or Not allowing Team Surgeon to be reimbursed (No). We should produce a code list that has either a Y or N value.
Summary DATE	**May 10, 2013**

Attachment E

HB 10-332 Colorado Medical Clean Claims Transparency & Uniformity Task Force

Edit/Payment Rule Query

Topic	**Age**
Definition	This type of edit will identify incorrect billing when the descriptor of the service/procedure code implies age-specific parameters.
Associated CPT® [1]and HCPCS codes	TBD
Query logic	The Edit Committee has not identified any public source available to generate a list of age specific edits. Payers receive these edits through their vendors. We expect to receive these edits during the payer submission. Payer submission should submit their age specific edits in ranges and should be provided in monthly values (i.e. 2 months – 59 months).
Rationale	We will assess the edits when payers submit them for consideration.
Summary DATE	**May 10, 2013**

Attachment F

HB 10-332 Colorado Medical Clean Claims Transparency & Uniformity Task Force

Edit/Payment Rule Query

Topic	**Gender**
Definition	This type of edit will identify incorrect billing when the descriptor of service/procedure code implies gender-specific parameters
Associated CPT® [1]and HCPCS codes	TBD
Query logic	The Edit Committee has not identified any public source available to generate a list of gender specific edits. Payers receive these edits through their vendors. We expect to receive these edits during the payer submission. Payer submission should submit the following values: F = Female M= Male X =Both or Unknown
Rationale	We will assess the edits when payers submit them for consideration.
Summary DATE	**May 10, 2013**

Attachment G

K – Co-Surgery

Rules Committee Recommendation

Co-surgery reporting rule

Context

Colorado enacted the Medical Clean Claims Transparency and Uniformity Act in 2010. The act established a task force of industry and government representatives to develop a standardized set of health care claim edits and payment rules to process medical claims. It requires the task force to submit to the General Assembly and Department of Health Care Policy & Financing a report and recommendations for a uniform, standardized set of payment rules and claim edits to be used by all payers and providers in Colorado.

The existing statute also requires that contracting providers be given information sufficient for them to determine the compensation or payment for health care services provided, including: the manner of payment (e.g., fee-for-service, capitation); the methodology used to calculate any fee schedule; the underlying fee schedule; and the effect of any payment rules and edits on payment or compensation, C.R.S. 25-37-103.

If the coding reported does not adhere to this rule, the payer may make a decision to deny the claim line. This will be communicated on an electronic remittance advice (ERA) with a HIPAA Claim Adjustment Reason Code (CARC) and as appropriate a Remittance Advice Remark Code (RARC) to explain the reason for the chosen action. If an ERA is not utilized, the payer may use a clearly defined payer adjustment code, on a paper remittance advice.

Modifier Involved

62 – Two Surgeons

When 2 surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) (including add-on procedure(s) are performed during the same surgical session, separate code(s) may also be reported with modifier 62 added. **Note:** If a co-surgeon acts as an assistant in the performance of additional procedure(s), other than those reported with the modifier 62, during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.[1]

This rule is applicable for the specific situations identified for this modifier. There may be appropriate situations where multiple modifiers apply, however they are not covered in this rule.

[1] Current Procedural Terminology (CPT®), Fourth Edition. 2013. American Medical Association.

Co-Surgery rule

Procedures subject to the co-surgery adjustment are listed in the column labeled CO SURG of the Medicare Physician Fee Schedule (MPFS). [2]

The co-surgery adjustment applies to procedure codes listed in the column labeled CO SURG of the MPFS with an indicator of 1 or 2.

The co-surgery adjustment does not apply to procedure codes listed in the column labeled CO SURG of the MPFS with an indicator of 0 or 9.

Coding and adjudication guidelines

To code a surgery that involves two surgeons, it is necessary to have the operative reports of both surgeons involved in a particular case wherein each physician provided distinct services, with all services being part of one surgery. Co-surgery also refers to surgical procedures involving two surgeons performing the parts of the procedure simultaneously, e.g., heart transplant or bilateral knee replacements.

The guidelines for use of modifier 62 denote the circumstance in which an additional surgeon for a specific surgery acts not as an assistant at surgery, but actually performs a distinct portion of the procedure in the capacity of a co-surgeon, or second primary surgeon. The use of modifier 62 allows for greater versatility in reporting the services provided by each surgeon. From a Current Procedural Terminology (CPT®)[3] coding perspective, the use of the modifier 62 is not limited to those procedures performed by physicians of differing specialties and may be performed by physicians of the same specialy.

- Each surgeon should report the same distinct procedural code with the modifier 62 appended.

- In separate operative reports, each surgeon should report the individual procedure(s) he/she performed related to the definitive surgery. Each should include a copy of the notes when reporting the service to the third-party payer.

- If additional procedure(s) (including add-on procedure(s) are performed during the same surgical session each, physician may report the separate code(s) with modifier 62 added.

- If one surgeon does not use the modifier 62, the third-party payer may assume that the physician reporting the procedure without the modifier performed the entire procedure, despite the second physician reporting the procedure with the modifier 62. ACTION: Subject to payer review process.

- If the co-surgeon acts as an assistant in the performance of additional procedure(s), other than those reported with the modifier 62, during the same surgical session, those additional services may be reported by appending modifier 80 or 82 as appropriate.

Note: If surgeons of different specialties are each performing a different procedure (with specific CPT codes), neither the co-surgery nor multiple surgery rule apply (even if the procedures are

[2] References to the Medicare Physician Fee Schedule (MPFS) made in this document refer to the MPFS Relative Value File. Visit http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html to access the MPFS Relative Value file.

[3]

performed through the same incision). If one of the surgeons performs multiple procedures, the multiple procedure rules apply to that surgeon's services.

Code is eligible for co-surgery adjustment (indicator 1 or 2)

Procedure codes listed in the column labeled CO SURG of the MPFS with an indicator of 1 or 2 are subject to the co-surgery adjustment, which may be applied ONLY when 1) The co-surgery indicator is 1 or 2, signifying that the code is eligible for the adjustment; 2) the code is reported with modifier 62. ACTION: Eligible for co-surgery adjustment.

Code is NOT eligible for co-surgery adjustment (indicator 0 or 9)

Procedure codes listed in the column labeled CO SURG of the MPFS with an indicator of 0 or 9 are not eligible for the co-surgery adjustment. Either the procedure is a straight forward procedure, only one surgeon is required, or the concept does not apply. ACTION: Deny, not eligible for co-surgery adjustment.

Co-Surgery Indicators
The MPFS provides four indicators (0,1, 2, and 9) used to identify procedure codes for which two surgeons, each of a different specialty, may be paid. The Rules Committee has outlined the following recommendations as they relate to the indicators:

- Procedure codes outlined in the column labeled CO SURG of the MPFS with an indicator of 0 are not recognized under the co-surgery rule.
- Procedure codes outlined in the column labeled CO SURG of the MPFS with an indicator of 1 are appropriate to report co-surgeons' efforts to be paid.
- Procedure codes outlined in the column labeled CO SURG of the MPFS with an indicator of 2 are appropriate to report co-surgeons' efforts to be paid.
- Procedure codes outlined in the column labeled CO SURG of the MPFS with an indicator of 9 are not recognized for reporting co-surgeons' efforts because the concept does not apply

Rationale

The following rationale was used to formulate the Rule Committee Recommendation:
- The CPT coding guidelines and conventions and national medical specialty society coding guidelines were reviewed.
- The CPT descriptions for co-surgery and modifier 62 were selected.
- The Centers for Medicare and Medicaid Services (CMS) pricing policy as identified in the MPFS and the Medicare Claims Processing Manual[4] were selected.
- CPT codes that were exceptions to the CMS pricing policy were identified and included in the Rule Committee Recommendation.

Exceptions

Refer to Appendix A for exceptions to the Rules Committee Recommendation.

MCCTF comment

Modifier 62 would be appended according to CPT definition.

Modifier definitions

[4] Chapter 12 – Physician/Nonphysician Practitioners, *Medicare Claims Processing Manual*, Publication # 100-04.

This type of edit will identify when consideration for payment will be made to two surgeons reporting that they were the primary surgeon when performing a distinct part(s) of a single surgical procedure. Consensus on 3/28/12

Modifier 62: Two Surgeons
When 2 surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) (including add-on procedure(s) are performed during the same surgical session, separate code(s) may also be reported with modifier 62 added. **Note:** If a co-surgeon acts as an assistant in the performance of additional procedure(s), other than those reported with the modifier 62, during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.[5]

Co-surgery indicator definitions

The following are indicator definitions that are outlined in the MPFS in the column labeled CO SURG for co-surgeons[6]. This field provides an indicator for services for which two surgeons, each in a different specialty, may be paid.

0 = Co-surgeons not permitted for this procedure.

1 = Co-surgeons could be paid. Supporting documentation is required to establish medical necessity of two surgeons for the procedure.

2 = Co-surgeons permitted. No documentation is required if two specialty requirements are met.

9 = Concept does not apply.

Federation outreach

American Academy of Orthopaedic Surgeons (AAOS)
This recommendation was sent to Matt Twetten and Joanne Willer for review.

American College of Radiology (ACR)
This recommendation has been viewed and approved by Pam Kassing and Diane Hayek of ACR.

American College of Surgeons (ACS)
This recommendation was sent to Jennifer Jackson for review.

American Congress of Obstetricians and Gynecologists (ACOG)
This recommendation has been viewed by the ACOG Coding Committee and ACOG has no issues. This policy conforms to both the CPT and RBRVS policies and practice.

Federation Payment Policy Workgroup
This recommendation has been sent to the Federation Payment Policy Workgroup for review.

[5] Current Procedural Terminology (CPT®), Fourth Edition. 2013. American Medical Association.
[6] Information taken from "How to Use the Searchable Medicare Physician Fee Schedule (MPFS)", Centers for Medicare & Medicaid Services.

K – Co-Surgery

Appendix A - To be added to Data Sustaining Repository

Rationale

The following rationale was used to formulate the Rules Committee Recommendation:

- The Current Procedural Terminology (CPT®)[7] coding guidelines and conventions and national medical specialty society coding guidelines were reviewed.
- The CPT descriptions for bilateral service and modifier 50 were selected.
- The Centers for Medicare and Medicaid Services (CMS) pricing policy, as identified in the Medicare Physician Fee Schedule (MPFS) and the Medicare Claims Processing Manual[8], were selected.
- CPT codes that were exceptions to the CMS pricing policy were identified and included in the Rule Committee Recommendation.

Exceptions

At the time of the initial review, the following exceptions were identified. This may not be a comprehensive listing of appropriate exceptions.

Spinal (Vertebral Column)

The musculoskeletal system procedure codes listed below were reviewed by CPT. The following codes should not be appended with modifier 62 and are not eligible for to the co-surgery adjustment. These codes should be considered to have a CMS Medicare Physician Fee Schedule (MPFS)[9] indicator of 0.

Surgery/Musculoskeletal System

20900	Bone graft, any donor area; minor or small (eg, dowel or button)
20902	major or large
20920	Fascia lata graft; by stripper
20922	by incision and area exposure, complex or sheet
20924	Tendon graft, from a distance (eg, palmaris, toe extensor, plantaris)
20931	Allograft, structural, for spine surgery only (List separately in addition to code for primary procedure)
20937	morselized (through separate skin or fascial incision) (List separately in addition to code for primary procedure)
20938	structural, bicortical or tricortical (through separate skin or fascial incision) (List separately in addition to code for primary procedure)
22840	Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar

	wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure)
22842	Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (List separately in addition to code for primary procedure)
22843	7 to 12 vertebral segments (List separately in addition to code for primary procedure)
22844	13 or more vertebral segments (List separately in addition to code for primary procedure)
22845	Anterior instrumentation; 2 to 3 vertebral segments (List separately in addition to code for primary procedure)
22846	4 to 7 vertebral segments (List separately in addition to code for primary procedure
22847	8 or more vertebral segments (List separately in addition to code for primary procedure)
22848	Pelvic fixation (attachment of caudal end of instrumentation to pelvic bony structures) other than sacrum (List separately in addition to code for primary procedure)
22850	Removal of posterior nonsegmental instrumentation (eg,Harrington rod)
22851	Application of intervertebral biomechanical device(s) (eg, synthetic cage(s), methylmethacrylate) to vertebral defect or interspace (List separately in addition to code for primary procedure)
22852	Removal of posterior segmental instrumentation

Attachment H

L – Team Surgery

Rules Committee Recommendation

Context

Colorado enacted the Medical Clean Claims Transparency and Uniformity Act in 2010. The act established a task force of industry and government representatives to develop a standardized set of health care claim edits and payment rules to process medical claims. It requires the task force to submit to the General Assembly and Department of Health Care Policy & Financing a report and recommendations for a uniform, standardized set of payment rules and claim edits to be used by all payers and providers in Colorado.

The existing statute also requires that contracting providers be given information sufficient for them to determine the compensation or payment for health care services provided, including: the manner of payment (e.g., fee-for-service, capitation); the methodology used to calculate any fee schedule; the underlying fee schedule; and the effect of any payment rules and edits on payment or compensation, C.R.S. 25-37-103.

If the coding reported does not adhere to this rule, the payer may make a decision to deny the claim line. This will be communicated on an electronic remittance advice (ERA) with a HIPAA Claim Adjustment Reason Code (CARC) and as appropriate a Remittance Advice Remark Code (RARC) to explain the reason for the chosen action. If an ERA is not utilized, the payer may use a clearly defined payer adjustment code, on a paper remittance advice.

Modifier involved

66 – Surgical Team

Under some circumstances, highly complex procedures (requiring the concomitant services of several physicians or other qualified health care professionals, often of different specialties, plus other highly skilled, specially trained personnel, various types of complex equipment) are carried out under the "surgical team" concept. Such circumstances may be identified by each participating individual with the addition of modifier 66 to the basic procedure number used for reporting services. [1]

This rule is applicable for the specific situations identified for this modifier. There may be appropriate situations where multiple modifiers apply, however they are not covered in this rule.

Team Surgery rule

Procedures subject to the team surgery adjustment are listed in the column labeled TEAM SURG of the Medicare Physician Fee Schedule (MPFS)[2]

[1] Current Procedural Terminology (CPT®), Fourth Edition. 2013. American Medical Association.
[2] References to the Medicare Physician Fee Schedule (MPFS) made in this document refer to the MPFS Relative Value File. Visit http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html to access the MPFS Relative Value file.

The team surgery adjustment applies to procedure codes listed in the column labeled TEAM SURG of the MPFS with an indicator of 1 or 2.

The team surgery adjustment does not apply to procedure codes listed in the column labeled TEAM SURG of the MPFS with an indicator of 0 or 9.

In the case of team surgery, the physicians or other qualified health care professionals are not acting as assistants-at-surgery.

Coding and adjudication guidelines

In certain Current Procedural Terminology (CPT®)[3] codes, one major procedure is listed without indicating the various components of that service that combines the work of several physicians and other specially trained personnel. If additional services are provided by any of the physicians on the surgical team, this should be indicated in a specific operative note.

- Each surgeon or qualified health care professional should report the distinct procedural code for the services provided with the modifier 66 appended.

- In separate operative reports, each surgeon and/or health care professional should report the individual procedure(s) he/she performed related to the definitive surgery. Each should include a copy of the notes when reporting the service to the third-party payer.

- If one surgeon assists another surgeon with a procedure, then modifiers 80 - Assistant Surgeon, 81 - Minimum Assistant Surgeon, or 82 - Assistant Surgeon (when qualified resident surgeon not available) may be more appropriate to report than modifier 66.

Code is eligible for team surgery adjustment (indicator 1 and 2)

Procedure codes listed in the column labeled TEAM SURG of the MPFS with an indicator of 1 or 2 are subject to the team surgery adjustment, which may be applied ONLY when 1) The team surgery indicator is 1 or 2, signifying that the code is eligible for the adjustment; 2) the code is reported with modifier 66. ACTION: Eligible for team surgery adjustment.

Code is NOT eligible for team surgery adjustment (indicators 0 and 9)

Procedure codes listed in the column labeled TEAM SURG of the MPFS with an indicator of 0 or 9 cannot be performed in the team surgery setting due to information constraints (e.g., straight forward procedure, only one surgeon required) or the concept does not apply. ACTION: Deny, not eligible for team surgery adjustment.

Team Surgery Indicators
The MPFS provides four indicators (0, 1, 2, and 9) used to report team surgeon participation in the service for which the procedure code is reported. The Rules Committee has outlined the following recommendations as they relate to the indicators:

- Procedure codes outlined in column labeled TEAM SURG of the MPFS with an indicator of 0 are not recognized under the team surgery rule.
- Procedure codes outlined in the column labeled TEAM SURG of the MPFS with an indicator of 1 are appropriate to report team surgeon effort.
- Procedure codes outlined in the column labeled TEAM SURG of the MPFS with an indicator of 2 are appropriate to report team surgeon effort;

[3]

- Procedure codes outlined in the column labeled TEAM SURG of the MPFS with an indicator of 9 should not be reported for team surgeons because the concept does not apply.

Rationale

The following rationale was used to formulate the Rule Committee Recommendation:
- The CPT coding guidelines and conventions and national medical specialty society coding guidelines were reviewed.
- The CPT descriptions for team surgery and modifier 66 were selected.
- The Centers for Medicare and Medicaid Services (CMS) pricing policy as identified in the MPFS and the Medicare Claims Processing Manual[4] were selected.
- CPT codes that were exceptions to the CMS pricing policy were identified and included in the Rule Committee Recommendation.

Exceptions

At the time of the initial review, there were no exceptions identified.

MCCTF comment

Modifier 66 would be appended according to CPT guidelines and instructions.

Modifier definitions

This type of edit will identify when consideration for payment will be made when a complex surgical procedure requires several physicians to act as a primary surgeon when performing a distinct part(s) of a single surgical procedure. Consensus on 3/28/12

Modifier 66: Surgical Team
Under some circumstances, highly complex procedures (requiring the concomitant services of several physicians or other qualified health care professionals, often of different specialties, plus other highly skilled, specially trained personnel, various types of complex equipment) are carried out under the "surgical team" concept. Such circumstances may be identified by each participating individual with the addition of modifier 66 to the basic procedure number used for reporting services. [5]

Team Surgery indicator definitions

The following are indicator definitions that are outlined in the MPFS in the column labeled TEAM SURG for team surgery[6]. This field provides an indicator for appropriate reporting of team surgeon services.

0 = Team surgeons not permitted for this procedure.

1 = Team surgeons could be paid. Supporting documentation is required to establish medical necessity of a team; paid by report.

[4] Chapter 12 – Physician/Nonphysician Practitioners, *Medicare Claims Processing Manual*, Publication # 100-04.
[5] Current Procedural Terminology (CPT®), Fourth Edition. 2013. American Medical Association.
[6] Information taken from "How to Use the Searchable Medicare Physician Fee Schedule (MPFS)", Centers for Medicare & Medicaid Services. ", Centers for Medicare & Medicaid Services.

2 = Team surgeons permitted; paid by report.

9 = Concept does not apply.

Federation outreach

American Academy of Orthopaedic Surgeons (AAOS)
This recommendation was sent to Matt Twetten and Joanne Willer for review.

American College of Radiology (ACR)
This recommendation has been viewed and approved by Pam Kassing and Diane Hayek of ACR.

American College of Surgeons (ACS)
This recommendation was sent to Jennifer Jackson for review.

American Congress of Obstetricians and Gynecologists (ACOG)
This recommendation has been viewed by the ACOG Coding Committee and ACOG has no issues. This policy conforms to both the CPT and RBRVS policies and practice.

Federation Payment Policy Workgroup
This recommendation was sent to the Federation Payment Policy Workgroup for review.

Attachment I

N – Bilateral Procedures

Rules Committee Recommendation

Bilateral payment adjustment and reporting rule

Context

Colorado enacted the Medical Clean Claims Transparency and Uniformity Act in 2010. The act established a task force of industry and government representatives to develop a standardized set of health care claim edits and payment rules to process medical claims. It requires the task force to submit to the General Assembly and Department of Health Care Policy & Financing a report and recommendations for a uniform, standardized set of payment rules and claim edits to be used by all payers and providers in Colorado.

The existing statute also requires that contracting providers be given information sufficient for them to determine the compensation or payment for health care services provided, including: the manner of payment (e.g., fee-for-service, capitation); the methodology used to calculate any fee schedule; the underlying fee schedule; and the effect of any payment rules and edits on payment or compensation, C.R.S. 25-37-103.

If the coding reported does not adhere to this rule, the payer may make a decision to deny the claim line. This will be communicated on an electronic remittance advice (ERA) with a HIPAA Claim Adjustment Reason Code (CARC) and as appropriate a Remittance Advice Remark Code (RARC) to explain the reason for the chosen action. If an ERA is not utilized, the payer may use a clearly defined payer adjustment code, on a paper remittance advice.

Modifier Involved
50 – Bilateral Procedure

Unless otherwise identified in the listings, bilateral procedures that are performed at the same session should be identified by adding modifier 50 to the appropriate 5-digit code. [1]

This rule is applicable for the specific situations identified for this modifier. There may be appropriate situations where multiple modifiers apply, however not all situations are covered in this rule.

Bilateral payment adjustment rule

Procedures subject to the bilateral payment adjustment rule are listed in the column labeled BILT SURG of the Medicare Physician Fee Schedule (MPFS).[2]

The bilateral payment adjustment applies to procedure codes that are listed in the column labeled BILT SURG of the MPFS with an indicator of 1.

[1] Current Procedural Terminology (CPT®), Fourth Edition. 2013. American Medical Association.
[2] References to the Medicare Physician Fee Schedule (MPFS) made in this document refer to the MPFS Relative Value File. Visit http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html to access the MPFS Relative Value file.

The bilateral payment adjustment does not apply to procedure codes that are listed in the column labeled BILT SURG of the MPFS with an indicator of 0, 2, 3 or 9.

A bilateral payment adjustment may be made ONLY when 1) The bilateral indicator is 1, signifying that the code is eligible for the adjustment; 2) the code is billed with modifier 50; 3) the code is billed on one line; and 4) the units are 1.

If bilateral procedures are performed with other procedures for the same patient during the same session by the same physician, apply the bilateral payment adjustment rule first, then apply any other applicable payment adjustment. (e.g. multiple surgery).

Coding and adjudication guidelines

Code is eligible for bilateral adjustment (bilateral indicator 1)

A bilateral payment adjustment may be made ONLY when 1) The bilateral indicator is 1, signifying that the code is eligible for the adjustment; 2) the code is billed with modifier 50; 3) the code is billed on one line; and 4) the units are 1.

Example: XXXXX 50

Use the following administrative guidelines if the above criteria are not met:

- Code is billed on two or more lines, each with 1 or more units, and one or more lines has modifier 50 - ACTION: Deny the lines or adjudicate one line using bilateral payment adjustment, deny other lines with the same procedure code if no additional modifier is appropriately appended.

  Example: XXXXX 50
  XXXXX 50 - subject to action

- Code is billed on two or more lines, each with 1 or more units, and no modifiers – ACTION: Deny the lines or adjudicate one line with no bilateral payment adjustment, deny other lines with same procedure code.

  Example: XXXXX – subject to action
  XXXXX – subject to action

Code is NOT eligible for bilateral adjustment (bilateral indicator 0 or 9)

Procedure codes listed in the column labeled BILT SURG of the MPFS with an indicator of 0 or 9 should be billed on one line. Either the procedure cannot be performed bilaterally due to anatomical constraints, there is a code that more adequately describes the bilateral procedure, or the concept does not apply.

Example: XXXXX

Use the following administrative guidelines if the above criteria are not met:

- Code is billed with modifier 50 appended – ACTION: Deny the line or adjudicate as if 1 unit had been billed without modifier 50 appended.

  Example: XXXXX 50 – subject to action

Code is inherently bilateral so NOT eligible for bilateral adjustment (bilateral indicator 2)

Procedure codes listed in the column labeled BILT SURG of the MPFS with an indicator of 2 should be billed on one line with 1 unit. Use of modifier 50 is inappropriate and it should not be appended.

Example: XXXXX

Use the following administrative guidelines if the above criteria are not met:

- If a procedure code with an indicator of 2 is billed on one line with modifier 50 appended or more than 1 unit – ACTION: Deny the line or adjudicate 1 unit.

  Example: XXXXX 50 – subject to action

- If procedure codes with an indicator of 2 are billed on two or more lines without an appropriate modifier – ACTION: Deny the line(s) or adjudicate one line with no bilateral payment adjustment, deny other line(s) with same procedure code and no ***appropriate modifier.***

  Example: XXXXX
  XXXXX – subject to action

Procedure is performed bilaterally and no bilateral adjustment is applied (bilateral indicator 3)

Procedure codes listed in the column labeled BILT SURG of the MPFS with an indicator of 3 should be billed on two lines, each line with 1 unit and one line with RT and one line with LT modifiers appended.

Example: XXXXX RT
XXXXX LT

Use the following administrative guidelines if the above criteria are not met:

- If procedure codes with an indictor of 3 are billed on one line with RT and LT modifiers, and 1 or more units– ACTION: Deny the line or adjudicate one line with unilateral pricing.

  Example: XXXXX RT, LT – subject to action

- If procedure codes with an indicator of 3 are billed on more than two lines with at least one line with RT and one line with LT and 1 or more units on these lines – ACTION: Adjudicate the combination of one RT line and one LT line with no bilateral payment adjustment. Deny other line(s) for same procedure code with RT/LT modifier and no other ***appropriate modifier.***

  Example: XXXXX RT
  XXXXX LT
  XXXXX RT – subject to action
  XXXXX LT, additional modifier

- If procedure codes with an indicator of 3 are billed on two or more lines with the appropriate RT and/or LT modifier(s) and appropriate additional modifiers, but with a

quantity of more than 1 unit per line. ACTION: Deny the line(s) or adjudicate the line(s) for 1 unit per line with no bilateral payment adjustment.

Example: XXXXX RT, unit 2 or more - subject to action
XXXXX LT, unit 2 or more - subject to action

- If procedure codes with an indicator of 3 are billed on two or more lines without an appropriate modifier - ACTION: Deny the line(s) or adjudicate one line with unilateral pricing.

Example: XXXXX – subject to action
XXXXX – subject to action

Bilateral Indicators
The MPFS has identified five indicators (0, 1, 2, 3 and 9) used to outline the payment adjustment for each procedure code. The Edit Committee is looking further into the MPFS as it relates to the bilateral concept. The Rules Committee has outlined the following recommendations as they relate to the indicators:

- Procedure codes listed in the column labeled BILT SURG of the MPFS with an indicator of 0 are not eligible for bilateral payment adjustment. Either the procedure cannot be performed bilaterally due to anatomical constraints or there is a code that more adequately describes the bilateral procedure.
- Procedure codes listed in the column labeled BILT SURG of the MPFS with an indicator of 1 are eligible for bilateral payment adjustment and should be reported on one line appended with modifier 50, with 1 in the units box.
- Procedure codes listed in the column labeled BILT SURG of the MPFS with an indicator of 2 are not eligible for the bilateral payment adjustment. These procedure codes are already bilateral.
- Procedure codes listed in the column labeled BILT SURG of the MPFS with an indicator of 3 are not eligible for bilateral payment adjustment. Report these codes on two lines with RT and LT. There is one payment per line. Indicator 3 codes are eligible for 1 unit per line.
- Procedure codes listed in the column labeled BILT SURG of the MPFS with an indicator of 9 are not eligible for the bilateral payment adjustment because the concept does not apply.

Rationale

The following rationale was used to formulate the Rule Committee Recommendation:
- The Current Procedural Terminology (CPT®)[3] coding guidelines and conventions and national medical specialty society coding guidelines were reviewed.
- The CPT descriptions for bilateral service and modifier 50 were selected.
- The Centers for Medicare and Medicaid Services (CMS) pricing policy as identified in the MPFS and the Medicare Claims Processing Manual[4] were selected.
- CPT codes that were exceptions to the CMS pricing policy were identified and included in the Rule Committee Recommendation.

Exceptions

Refer to Appendix A for exceptions to the Rules Committee Recommendation.

[3] Copyright 2013 American Medical Association. All rights reserved.
[4] Chapter 12 – Physician/Nonphysician Practitioners, *Medicare Claims Processing Manual*, Publication # 100-04.

MCCTF comments

As defined in CPT, Modifier 50 "Bilateral procedure description: Unless otherwise identified in the listing bilateral procedures that are performed at the same operative session should be identified by adding modifier 50 to the appropriate five digit code." Medicare further defined bilateral as, a bilateral service is one in which the same procedure is performed on both sides of the body during the same operative session or on the same day.

Modifier definition

This type of edit will identify incorrect billing when the CPT/HCPCS descriptors of the service/procedure code, or the related coding guidelines imply either unilateral or bilateral restrictions.

Modifier 50: Bilateral Procedure
Unless otherwise identified in the listings, bilateral procedures that are performed at the same session should be identified by adding modifier 50 to the appropriate 5-digit code.[5]

Bilateral indicator definitions

The following are indicator definitions that are outlined in the column labeled BILT SURG of the Medicare Physician Fee Schedule (MPFS) for Bilateral Surgery[6]. **Note**: The specific amounts associated with the differentiated payments are not within the purview of the Medical Clean Claims Transparency and Uniformity Act. Payment rule recommendations should not include budget restraints, political influences or benefit limitations. Percent payment adjustments and fee schedule amounts are listed below solely because they are outlined in the indicator definitions as defined in the MPFS and should not be considered as a recommendation of the Rules Committee.

0 = 150 percent payment adjustment for bilateral procedures does not apply. If a procedure is reported with modifier -50 or with modifiers RT and LT, Medicare bases payment for the two sides on the lower of: (a) the total actual charge for both sides or (b) 100 percent of the fee schedule amount for a single code. Example: The fee schedule amount for code XXXXX is $125. The physician reports code XXXXX-LT with an actual charge of $100 and XXXXX-RT with an actual charge of $100.

Payment would be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The bilateral adjustment is inappropriate for codes in this category because of (a) physiology or anatomy or (b) because the code descriptor specifically states that it is a unilateral procedure and there is an existing code for the bilateral procedure.

1 = 150 percent payment adjustment for bilateral procedures applies. If a code is billed with the bilateral modifier or is reported twice on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field), payment is based for these codes when reported as bilateral procedures on the lower of: (a) the total actual charge for both sides or (b) 150 percent of the fee schedule amount for a single code.

[5] Current Procedural Terminology (CPT®), Fourth Edition. 2013. American Medical Association.
[6] Information taken from "How to Use the Searchable Medicare Physician Fee Schedule (MPFS)", Centers for Medicare & Medicaid Services.

If code is reported as a bilateral procedure and is reported with other procedure codes on the same day, the bilateral adjustment is applied before applying any applicable multiple procedure rules.

2 = 150 percent payment adjustment for bilateral procedure does not apply. RVUs are already based on the procedure being performed as a bilateral procedure. If a procedure is reported with modifier -50 or is reported twice on the same day by any other means (e.g., with RT and LT modifiers with a 2 in the units field), payment is based for both sides on the lower of (a) the total actual charges by the physician for both sides or (b) 100 percent of the fee schedule amount for a single code. Example: The fee schedule amount for code YYYYY is $125. The physician reports code YYYYY-LT with an actual charge of $100 and YYYYY-RT with an actual charge of $100.

Payment would be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The RVUs are based on a bilateral procedure because: (a) the code descriptor specifically states that the procedure is bilateral; (b) the code descriptor states that the procedure may be performed either unilaterally or bilaterally; or (c) the procedure is usually performed as a bilateral procedure.

3 = The usual payment adjustment for bilateral procedures does not apply. If procedure is reported with modifier -50 or is reported for both sides on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field), Medicare bases payment for each side or organ or site of a paired organ on the lower of: (a) the actual charge for each side or (b) 100 percent of the fee schedule amount for each side. If procedure is reported as a bilateral procedure and with other procedure codes on the same day, the fee schedule amount for a bilateral procedure is determined before applying any applicable multiple procedure rules. Services in this category are generally radiology procedures or other diagnostic tests, which are not subject to the special payment rules for other bilateral procedures.

9 = Concept does not apply.

Federation outreach

American Academy of Orthopaedic Surgeons (AAOS)
This recommendation has been viewed Matt Twetten and Joanne Willer. It was recommended the CPT codes 27215-27218 follow the Rules Committee recommendations when billed bilaterally.

American College of Radiology (ACR)
This recommendation has been viewed and approved by Pam Kassing and Diane Hayek of ACR.

American College of Surgeons (ACS)
This recommendation was sent to Jennifer Jackson for review.

Federation Payment Policy Workgroup
This recommendation was sent to the Federation Payment Policy Workgroup for review.

N – Bilateral Procedures

Appendix A - To be added to Data Sustaining Repository

Rationale

The following rationale was used to formulate the Rules Committee Recommendation:

- The Current Procedural Terminology (CPT®)[7] coding guidelines and conventions and national medical specialty society coding guidelines were reviewed.
- The CPT descriptions for bilateral service and modifier 50 were selected.
- The Centers for Medicare and Medicaid Services (CMS) pricing policy, as identified in the Medicare Physician Fee Schedule (MPFS)[8] and the Medicare Claims Processing Manual[9], were selected.
- CPT codes that were exceptions to the CMS pricing policy were identified and included in the Rule Committee Recommendation.

Exceptions

At the time of the initial review, the following exceptions were identified. This may not be a comprehensive listing of appropriate exceptions.

Surgery

The orthopaedic procedure codes listed below have the following indicator in the MPFS:

> I = Not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, these services. (Code **NOT** subject to a 90-day grace period.)

These codes were reviewed by CPT and, when performed bilaterally, are subject to the bilateral payment adjustment rule. These codes should be considered to have an MPFS indicator of 1.

27215	Open treatment of iliac spine(s), tuberosity avulsion, or iliac wing fracture(s), unilateral, for pelvic bone fracture patterns that do not disrupt the pelvic ring, includes internal fixation, when performed
27216	Percutaneous skeletal fixation of posterior pelvic bone fracture and/or dislocation, for fracture patterns that disrupt the pelvic ring, unilateral (includes ipsilateral ilium, sacroiliac joint and/or sacrum)
27217	Open treatment of anterior pelvic bone fracture and/or dislocation for fracture patterns that disrupt the pelvic ring, unilateral, includes internal fixation, when performed (includes pubic symphysis and/or ipsilateral superior/inferior rami)
27218	Open treatment of posterior pelvic bone fracture and/or dislocation, for fracture patterns that disrupt the pelvic ring, unilateral, includes internal fixation, when performed (includes ipsilateral ilium, sacroiliac joint and/ or sacrum)

[7] Copyright 2013 American Medical Association. All rights reserved.
[8] References to the Medicare Physician Fee Schedule (MPFS) made in this document refer to the MPFS Relative Value File. Visit http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html to access the MPFS Relative Value file.
[9] Chapter 12 – Physician/Nonphysician Practitioners, *Medicare Claims Processing Manual*, Publication # 100-04.

Category III CPT Codes

The following Category III CPT codes for emerging technology are not represented in the MPFS. These codes were reviewed by CPT and, when performed bilaterally, are subject to the bilateral payment adjustment rule. These codes should be considered to have an MPFS indicator of 1.

0187T	Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral
0037T	Open subclavian to carotid artery transposition performed in conjunction with endovascular thoracic aneurysm repair, by neck incision, unilateral
0135T	Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy

Attachment J

HB 10-332 Colorado Medical Clean Claims Transparency & Uniformity Task Force

Edit/Payment Rule

Number: PR0001613	**Statutory reference: C.R.S. 25-37-106**
Topic	**Assistant at surgery**
Definition	In the performance of a surgical procedure, an assistant to the surgeon may be required to successfully complete the procedure. Assistants at surgery represent their services by appending the modifiers listed below to the surgical procedure code.
Associated CPT®[1] and HCPCS modifiers	-80 Assistant Surgeon: Surgical assistant services may be identified by adding modifier 80 to the usual procedure number(s). -81 Minimum assistant Surgeon: Minimum surgical assistant services are identified by adding modifier 81 to the usual procedure number. -82 Assistant Surgeon (when qualified resident surgeon not available). The unavailability of a qualified resident surgeon is a prerequisite for the use of modifier 82 appended to the usual procedure code number(s). -AS Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist services for assistant at surgery.
Rationale	In order to develop the assistant surgery definition to be used as part of the standard edit set, the Edit Committee has reviewed the publically available listings that identify which CPT procedure codes are eligible for an assistant at surgery. Two such lists are published, one by the American College of Surgeons (ACS) and the other by the Centers for Medicare and Medicaid Services (CMS). The lists are not identical. Members of the Clean Claim Colorado Task Force gave strong credence to the value of clinical input in determining whether an assistant surgeon would be eligible for reimbursement. The American College of Surgeons (ACS) published their recommendation in a publication called "Physicians as Assistants at Surgery: 2011 Study". The committee agreed that when clinical input was provided by the American College of Surgeons it would be the first source utilized to determine whether an assistant at surgery was reimbursable. However, given the frequency of the publication, the committee also agreed that an alternate source would be needed to supplement the list. The Centers for Medicare and Medicaid Services (CMS) was chosen as the alternate source. Additionally, Members of the Task Force focused on the administrative expense associate with reviewing claims. The committee recommended the assistant surgery eligibility list would have either an approved or not eligible status to provide for automated adjudication. There was a concern that changing the SOMETIMES to an automatic ALWAYS or NEVER could have an adverse financial impact on either the payers or providers and compromise the acceptability of the Task Force's standardized edit set by the industry. Therefore ~~the procedure codes identified through the rule logic noted below as SOMETIMES will be defaulted to NEVER~~ before the Task Force makes a final decision regarding the procedure codes identified through the rule logic noted below as SOMETIMES, we are seeking information from the public that provides data to support the use of a default to ALWAYS or NEVER.

[1] [1] Copyright 2013 American Medical Association. All rights reserved.

	Further recognition was given to the fact that every clinical situation can be different. Surgical services that are not eligible for assistant surgery reimbursement can be appealed to the health plan for reconsideration with the appropriate supporting medical records.

Rule logic	The Assistant Surgeon list was developed by reviewing the most current publication from the American College of Surgeons (ACS).
	• A recommendation of Almost Always from ACS was agreed to be considered an Always reimburse.
	• A recommendation of Almost Never was agreed to be considered as Not Eligible for reimbursement.
	• When the ACS recommendation was Sometimes or the ACS did not make a recommendation on a surgical code (i.e. the code was effective after the date of the most recent publication), then the Centers for Medicare and Medicaid Services (CMS) National Physician Fee schedule was reviewed.
	• The Assistant Surgeon column was reviewed.
	  ○ If the CMS indicator is a 2 (Always), then the recommendation would be accepted as Always reimburse.
	  ○ If the CMS indicator is a 1 (Never), then the recommendation would be accepted as Not Eligible for reimbursement.
	  ○ If the CMS indicator is a 0 (Sometimes), then they will be recommended as ~~Not eligible fore reimbursement.~~*TBD based on additional information provided through public comment*.
	Only CPT® and HCPCS surgical procedure codes were considered as part of this rule as an assistant is not generally medically necessary for non-surgical procedures.

Administrative guidance	As part of the promise of HB 10-1332 was administrative simplification, the Edit Sub-Committee recommends that the assistant surgery decision should initially always be a yes or no, rather than indicating that the SOMETIMES indicators of the source listings be PENDED for review of the medical necessity in our data set. If the coding reported does not adhere to this rule, the payer may make a decision to deny the claim line, this will be communicated on an electronic remittance advice (ERA) with a HIPAA Claim Adjustment Reason Code (CARC) and as appropriate a Remittance Advice Remark Code (RARC) to explain the reason for the chosen action. If an ERA is not utilized, the payer may use a clearly defined payer adjustment code, on a paper remittance advice.
Specialty Society outreach	Specialty society outreach was conducted. The American College of Orthopaedic Surgeons (AAOS) and the American College of Surgeons (ACS) were both consulted.
Summary **DATE**	**The task force will publish a list of the procedure codes for surgical services that are eligible/not eligible for assistant surgery reimbursement. The list may be updated quarterly when new codes are developed or the source information changed. The rule logic identified in this document will be utilized when considering new codes.** **NOTE: The public is asked to supply data that can be used to inform the decision to default the 378 procedures that fall into the SOMETIMES-SOMETIMES category (listed on the following page) to either ALWAYS or NEVER.** **May 21, 2013**

Context

Colorado enacted the Medical Clean Claims Transparency and Uniformity Act in 2010. The act established a task force of industry and government representatives to develop a standardized set of health care claim edits and payment rules to process medical claims. It requires the task force to submit to the General Assembly and

Department of Health Care Policy & Financing a report and recommendations for a uniform, standardized set of payment rules and claim edits to be used by all payers and providers in Colorado.

The existing statute also requires that contracting providers be given information sufficient for them to determine the compensation or payment for health care services provided, including: the manner of payment (e.g., fee-for-service, capitation); the methodology used to calculate any fee schedule; the underlying fee schedule; and the effect of any payment rules and edits on payment or compensation, C.R.S. 25-37-103.

Comments

The Task Force is working within the legislative framework of Colorado Revised Statutes Section 25-37-106 which outlines the sources to be used in the development of a standardized set of claims edits and payment rules. These parameters should be taken into consideration when providing comments.

Comments regarding the assistant at surgery rule should be submitted online to the Colorado Medical Clean Claims Task Force at xxxxxx by June xx 2013. The following information should be included:

1. Number and topic
2. Position – support, disagree, modification
3. Recommendation
4. Rationale in support of recommendation
5. Supporting data and sources, e.g., frequency, associated costs
6. Estimated impact of the proposed rule
7. Contact information
8. Organization affiliation

Attachment K

Recipe Development Tracking

Rules

A – Unbundled (PTP)
B – Mutually Exclusive
C – Multiple Procedure Reduction
D – Age
E – Gender
F – Maximum Frequency Per Day
G – Global Surgery Days
H – Place of Service
J – Assistant at Surgery
K – Co-Surgery
L – Team Surgery
M – Total/Professional/Technical Split
N – Bilateral Procedures
O – Anesthesia Services
P – Effect of CPT© & HCPCS Modifiers on edits: 24, 25, 26, 50, 51, 54, 55, 56, 57, 58, 59, 62, 63, 66, 76, 77, 78, 79, 80, 81, 82, 91, 99, AS, EY, E1, E2, E3, E4, FA, F1, F2, F3, F4, F5, F6, F7, F8, F9, GD, LC, LD, LT, P1, P2, P3, P4, P5, P6, QK, QS, QY RC, RT, TA, TC, T1, T2, T3, T4, T5, T6, T7, T8, T9
Add-ons
Maximum Frequency > one/day
New Patient
Bundled Service (status B)

Rule	EC Comments Sign Off	PRC Comments Sign Off	DSR Comments Sign Off	TF Review – Refer to Comm.	TF Consensus	Release for Public Comment	Revise Based on Comments	TF Consensus FINAL RULE
A-Unbundle (PTP)	Defined							
B-Mutually Exclusive	Defined							
C-Multiple Procedure Reduction	Defined							
D-Age	Defined 5/21/13 DSR queries drafted							
E-Gender	Defined 5/21/13 DSR queries drafted							

Rule	EC Comments Sign Off	PRC Comments Sign Off	DSR Comments Sign Off	TF Review – Refer to Comm.	TF Consensus	Release for Public Comment	Revise Based on Comments	TF Consensus FINAL RULE
F-Maximum Frequency Per Day	Defined							
G-Global Surgery Days	Defined	In process						
H-Place of Service	Defined							
J-Asst. Surgery	Recommendation to TF/approved 5/23/12 Revised query scenarios		Tested logic 3/27/13 with TF. Revised/retested 4/17, results to TF 4/24/13	3/27/13 referred back to EC	4/24/13 Reconsider 5/21/13			
K-Co-surgery	Defined 5/21/13 DSR queries drafted	Recommendation 5/21/13						
L-Team Surgery	Defined 5/21/13 DSR queries drafted	Recommendation 5/21/13						
M- Total/Prof./ Tech. Split	Defined							
N-Bilateral Procedures	Defined	Recommendation 5/21/13						
O-Anesthesia Services	Defined							
P- Modifiers effect on edits:								
24	Defined							
25	Defined							
26	Defined							
50	Defined	Addressed in Bilateral						

Rule	EC Comments Sign Off	PRC Comments Sign Off	DSR Comments Sign Off	TF Review – Refer to Comm.	TF Consensus	Release for Public Comment	Revise Based on Comments	TF Consensus FINAL RULE
		Procedure						
51	Defined							
54	Defined							
55	Defined							
56	Defined							
57	Defined							
58	Defined							
59	Defined							
62	Defined							
63	Defined							
66	Defined							
76	Defined							
77	Defined							
78	Defined							
79	Defined							
80	Defined	Addressed in Asst. Surgery						
81	Defined	Addressed in Asst. Surgery						
82	Defined	Addressed in Asst. Surgery						
91	Defined							
AS	Defined	Addressed in Asst. Surgery						
EY	Defined							
E1	Defined							
E2	Defined							
E3	Defined							
E4	Defined							
FA	Defined							

Rule	EC Comments Sign Off	PRC Comments Sign Off	DSR Comments Sign Off	TF Review – Refer to Comm.	TF Consensus	Release for Public Comment	Revise Based on Comments	TF Consensus FINAL RULE
F1	Defined							
F2	Defined							
F3	Defined							
F4	Defined							
F5	Defined							
F6	Defined							
F7	Defined							
F8	Defined							
F9	Defined							
GD	Defined							
LC	Defined							
LT	Defined	Addressed in Bilateral Procedure						
P1	Defined							
P2	Defined							
P3	Defined							
P4	Defined							
P5	Defined							
P6	Defined							
QK	Defined							
QS	Defined							
QY	Defined							
RC	Defined							
RT	Defined	Addressed in Bilateral Procedure						
TA	Defined							
TC	Defined							
T1	Defined							

Rule	EC Comments Sign Off	PRC Comments Sign Off	DSR Comments Sign Off	TF Review – Refer to Comm.	TF Consensus	Release for Public Comment	Revise Based on Comments	TF Consensus FINAL RULE
T2	Defined							
T3	Defined							
T4	Defined							
T5	Defined							
T6	Defined							
T7	Defined							
T8	Defined							
T9	Defined							
Add-ons	Defined							
Max. Frequency-Span of Days	Defined							
New Patient	Defined							
Bundled Service (Status B)	Defined							